TMA Uniform Business Office

What Your Resource Manager Should Know Before He Allocates Funds

Presented by the
TMA Uniform Business Office
Program Manager

Overview

- Coding Foundations
  - Institutional
  - Professional
- Why you need quality data
- Examples of poor quality data

Goals

1. **Given a number of answers, 80% of the time select the reasons why you need quality data to run a health care organization.**
   - **Goal 3, Providing globally accessible health and business information to enhance mission effectiveness.**
2. **Given a number of examples of poor data and quality data, 80% of the time select quality data examples.**
   - **Goal 4, Transformation to performance based management for both force health protection and delivery of the health care benefit.**

Coding Foundations

Institutional - (the nurses, technicians, supplies, facility)

- Hospital inpatient → ICD-9 diagnoses and ICD-9 procedures → Diagnosis Related Group (DRG) → Relative Weighted Product
- Ambulatory Procedure Visit in a bedded MTF operating room → CPT procedure → Ambulatory Payment Classification (APC)
- Ambulatory Procedure Visit in a non-bedded MTF operating room → CPT procedure → Ambulatory Surgery Center category (ASC)

Inpatient Institutional –
Relative Weighted Product (RWP)
In TRICARE Management Activity (TMA) Prospective Payment System (PPS) 1 RWP = $6,877

DRGV22	DRG TITLE	RELATIVE WEIGHTS	GEOMETRIC MEAN LOS	ARITHMETIC MEAN LOS
1	CRANIOTOMY AGE >17 W CC	3.3344	7.5	10.0
2	CRANIOTOMY AGE >17 W/O CC	1.9467	3.6	4.6
3	CRANIOTOMY AGE 0-17	1.9767	12.7	12.7
370	CESAREAN SECTION W CC	0.8981	4.2	5.4
371	CESAREAN SECTION W/O CC	0.6221	3.2	3.5
372	VAGINAL DELIVERY W COMPLICATING DIAGNOSES	0.5460	2.7	3.5
373	**VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES**	**0.3601**	**2.0**	**2.2**
374	VAGINAL DELIVERY W STERILIZATION &/OR D&C	0.6642	2.7	3.3
375	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	0.5810	4.4	4.4
504	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/SKIN GFT	13.0063	23.1	29.3
505	EXTEN. BURNS OR FULL THICKNESS BURN W/MV 96+HRS W/O SKIN GFT	1.8727	2.3	4.4
506	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC OR SIG TRAUMA	4.0604	11.6	16.2

Note: In TMA PPS one mental health bed day is $614

Ambulatory Payment Classification (APC)

any time you see 99199 or the outpatient **bedded** non-facility and facility pricing is the same

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate
96900	S		Ultraviolet light therapy (Actinotherapy)	0001	0.4007	22.83
38220	T		Bone marrow aspiration	0003	2.4779	141.20
60100	T		Biopsy of thyroid	0004	1.7081	97.33
42400	T		Biopsy of salivary gland	0005	3.7391	213.07
69000	T		Drain external ear	0006	1.6854	96.04
51080	T		Drainage of bladder	0007	12.4496	709.42
38300	T		Drainage, lymph node	0008	19.3572	1103.03
G0127	T		Trim nail(s)	0009	0.6817	38.85
G0247	T		Routine footcare pt w	0009	0.6817	38.85
19103	T		Bx breast percut	0658	6.6823	380.78
75982	S		Contrast xray exam bile	0297	5.2294	297.99
62230	T		Replace/revise brain	0224	38.8952	2216.37
64565	S		Implant neuroelectrodes	0040	49.2740	2807.78
36563	T		Insert tunneled cv cath	0119	125.9746	7178.41
69930	T		Implant cochlear device	0259	444.1223	25307.42

Office Visit (e.g., external resource sharing)/ Emergency Department APCs

CPT/ HCPCS	SI	CI	Description	APC	Relative Weight	Payment Rate
99201	V		Office/outpatient visit, new	0600	0.9033	51.47
99202	V		Office/outpatient visit, new	0600	0.9033	51.47
99203	V		Office/outpatient visit, new	0601	0.9847	56.11
99204	V		Office/outpatient visit, new	0602	1.3977	79.65
99205	V		Office/outpatient visit, new	0602	1.3977	79.65
99211	V		Office/outpatient visit, est	0600	0.9033	51.47
99212	V		Office/outpatient visit, est	0600	0.9033	51.47
99213	V		Office/outpatient visit, est	0601	0.9847	56.11
99214	V		Office/outpatient visit, est	0602	1.3977	79.65
99215	V		Office/outpatient visit, est	0602	1.3977	79.65
99281	V		Emergency dept visit	0610	1.3544	77.18
99282	V		Emergency dept visit	0610	1.3544	77.18
99283	V		Emergency dept visit	0611	2.3926	136.34
99284	V		Emergency dept visit	0612	4.1139	234.42
99285	V		Emergency dept visit	0612	4.1139	234.42

CMS APCs 2005, this is the INSTITUTIONAL component of the visit

About External Resource Sharing…

- External Resource Sharing – when your provider does work outside of your facility at a non-DoD facility
  - For example: delivers babies at Shreveport Hospital; does surgery at U of New Mexico hospital
- If you use a child DMIS, remember those encounters do NOT have an institutional component, the place where the work was done will bill an institutional to TRICARE

There used to be 9 Ambulatory Surgery Center Billing Groups in the civilian sector.

There used to be 11 ASC rates in the DoD

Now, CMS revamped the 9 to 56.

http://www.cms.hhs.gov/ASCPayment/

HCPCS	Short Descriptor	A =New to List; 2007 CPT changes A= Add D=Delete	OPPS Payment Rate	ASC Payment Group	ASC Payment Rate	DRA Cap	ASC Copayment Amount
10121	Remove foreign body		$928.31	2	$446.00		$89.20
10180	Complex drainage, wound		$1,076.22	2	$446.00		$89.20
11010	Debride skin, fx		$251.52	2	$251.52	Y	$50.30
11011	Debride skin/muscle, fx		$251.52	2	$251.52	Y	$50.30
11012	Debride skin/muscle/bone, fx		$251.52	2	$251.52	Y	$50.30
11042	Debride skin/tissue		$164.42	2	$164.42	Y	$32.88
11043	Debride tissue/muscle		$164.42	2	$164.42	Y	$32.88
11044	Debride tissue/muscle/bone		$423.10	2	$423.10	Y	$84.62
11404	Exc tr-ext b9+marg 3.1-4 cm		$928.31	1	$333.00		$66.60
11406	Exc tr-ext b9+marg > 4.0 cm		$928.31	2	$446.00		$89.20
11424	Exc h-f-nk-sp b9+marg 3.1-4		$928.31	2	$446.00		$89.20
11426	Exc h-f-nk-sp b9+marg > 4 cm		$1,233.39	2	$446.00		$89.20

New CMS Ambulatory Surgery Center Billing Groups/Rates

HCPCS	Short Descriptor	A*=New to List A=Add D=Delete	OPPS Payment Rate	ASC Payment Group	ASC Payment Rate	DRA Cap	ASC Copayment Amount	Former ASC group
11404	Exc tr-ext b9+marg 3.1-4 cm		$928.31	01	$333.00		$66.60	1
11444	Exc face-mm b9+marg 3.1-4 cm		$418.49	01	$333.00		$66.60	1
11971	Remove tissue expander(s)		$1,233.39	01	$333.00		$66.60	1
15001	Wound prep, addl 100 sq cm	D		01	$333.00			1
15111	Epidrm autogrft t/a/l add-on		$1,317.27	01	$333.00		$66.60	
15116	Epidrm a-grft f/n/hf/g addl		$1,317.27	01	$333.00		$66.60	
15131	Derm autograft t/a/l add-on		$1,317.27	01	$333.00		$66.60	

Coding Foundations

Institutional - (the nurses, technicians, supplies, facility)

- Emergency Department → as of ?? Feb 2007 (28 Jan 2007 for National Capital Area) HCPCS of G0380/G0381/G0382/G0283 /G0384 → Ambulatory Payment Classification (APC)
- Observation → CPT → APC
- In the doctor's office → CPT "Non-facility Practice Expense"

CMAC Detail Screen for Procedure Code: 99281
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

NOTE: Facility and Non-facility are the same – you need to ask "Where is the institutional?"

Procedure Code	*Description*
99281	**EMERGENCY DEPT VISIT**

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	**$18.07**
Category of Provider	**Facility Physician**
CMAC for Category 2	**$18.07**
Category of Provider	**Non-Facility Physician**
CMAC for Category 3	$15.36
Category of Provider	Facility Non-Physician
CMAC for Category 4	$15.36
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99217
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND

NOTE: Facility and Non-facility are the same – you need to ask "Where is the institutional?"

Procedure Code	*Description*
99217	**OBSERVATION CARE DISCHARGE**

Effective Date: 01-Mar-06 **Correction Date:** N/A **Term Date:** N/A

CMAC for Category 1	**$78.05**
Category of Provider	**Facility Physician**
CMAC for Category 2	**$78.05**
Category of Provider	**Non-Facility Physician**
CMAC for Category 3	$66.34
Category of Provider	Facility Non-Physician
CMAC for Category 4	$66.34
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99201
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

NOTE: Facility and Non-facility are not the same – here is the institutional

Procedure Code	*Description*
99201	**OFFICE/OUTPATIENT VISIT, NEW**

Effective	01-Mar-06	**Correction**	N/A	**Term**	N/A

CMAC for Category 1	$26.04
Category of Provider	Facility Physician
CMAC for Category 2	**$42.14**
Category of Provider	**Non-Facility Physician**
CMAC for Category 3	$22.13
Category of Provider	Facility Non-Physician
CMAC for Category 4	$35.82
Category of Provider	Non-Facility Non-Physician

Coding Foundations

Professional (what the privileged provider did)

- "Clinics" (e.g., Family Practice, Pediatrics, General Surgery, ENT) → CPT/HCPCS code → TMA Prospective Payment System (PPS) "**Work** Relative Value Unit (RVU)"
  - In civilian sector, if done in doctor's office/minor surgery suite, includes "Non-facility practice expense"
  - **TMA PPS "Work RVUs" is a surrogate for all RVUs earned in the clinics**
  - Issue for services with high "practice expense" such as Cardiac Cath Labs, Radiation Oncology
    - Using "CMAC" website for pricing – need to know when procedure is not done in doctor's office

- TMA PPS “Work RVUs” is a surrogate for all RVUs earned in the clinics
- Does this mean your Service (e.g., Army, Navy, Air Force) should also divide funds this way
  - I hope not
- Does this mean your MTF RMO should divide funds this way
  - I hope not

TMA PPS Uses “Work RVUs” Because:

- Does not currently have quantity and modifiers – but you do on your server
- Until this year, no separate code to collect Emergency Department institutional
- Inpatient professional coding is not yet optimal
- TMA coding audit indicated issues with quality of outpatient professional coding

Procedure Code 93526
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	Description
93526	RT & LT HEART CATHETERS

Effective Date:	01-Mar-06	Correction Date:	N/A	Term Date:	N/A

Pricing Type	Global	Professional	Technical
Physician	$2,786.74	**$385.78**	**$2,400.96**

Effective Date:	Correction Date:	Term Date:

Pricing Type	Global	Professional	Technical
NON-Physician	$2,728.87	$327.91	$2,400.96

Coding Foundations

Professional (what the privileged provider did)

- Understand when non-privileged providers do services normally billed in civilian sector
  - Anticoagulation Management - done by nurses, has practice expense, but not Work RVU – but need to consider each nurse encounter as if it was a provider encounter when considering sending these patients downtown
- Telephone calls – not normally reimbursed in civilian sector, if a patient who receives a significant amount of care via the telephone is “sent downtown” the telephone calls frequently become office visits
  - Many are nurse triage, in the civilian sector these would be billed by the doctors, so include when considering who should be sent downtown

Coding Foundations

Professional (what the privileged provider did)

- Emergency Department – CPT code is only the professional component, not the institutional
- Observation – CPT code is only the professional component, not the institutional
- Anesthesia – 0xxxx CPT code → Base Units → plus minute of service base units
  - Anesthesia is the most common error when coding Ambulatory Procedure Visits

Coding Foundations

Professional (what the privileged provider did)

- Radiology – collected in “D” MEPRS
  - Seeing a lot of guidance coded in “B” Ambulatory Procedure Visits and Pain Management
    - Is it also being coded in “D” by radiology staff? – if so you are “double dipping” by getting RVUs in the “B” clinic and paid costs in “D” Radiology
    - If only coded in “B” is radiologist time also collected in the “B” ? If so, you are looking like your radiologists don’t do anything but you have really productive pain management providers

Tmt_DMIS_ID_Name	MEPRS3_	cpt	cpt_desc	Encounters	cpt_rvu
NMC SAN DIEGO	BBL	76005	FLUOROGUIDE FOR SPINE	520	312
WALTER REED AMC-W	BBL	76005	FLUOROGUIDE FOR SPINE	2005	1203
NH JACKSONVILLE	BBL	76005	FLUOROGUIDE FOR SPINE	312	187.2
NNMC BETHESDA	BBL	76005	FLUOROGUIDE FOR SPINE	495	297
WOMACK AMC-FT. BR	BBL	76005	FLUOROGUIDE FOR SPINE	68	40.8
BROOKE AMC-FT. SAN	BBL	76005	FLUOROGUIDE FOR SPINE	1511	906.6
DARNALL AMC-FT. HO	BBL	76005	FLUOROGUIDE FOR SPINE	190	114
59TH MED WING-LACK	BBL	76005	FLUOROGUIDE FOR SPINE	714	428.4
NMC PORTSMOUTH	BBL	76005	FLUOROGUIDE FOR SPINE	2250	1350
MADIGAN AMC-FT. LE	BBL	76005	FLUOROGUIDE FOR SPINE	668	400.8
NH BREMERTON	BBL	76005	FLUOROGUIDE FOR SPINE	30	18
LANDSTUHL REGIONA	BBL	76005	FLUOROGUIDE FOR SPINE	484	290.4
NH OKINAWA	BBL	76005	FLUOROGUIDE FOR SPINE	47	28.2

Coding Foundations

- Sometimes Professional, Sometimes Institutional
  - Physical Therapy and Occupational Therapy
    - Outpatient – Professional → CPT → RVU
    - Inpatient – institutional - problem, no PT or OT inpatient “A” MEPRS or step down “E” MEPRS
      - Do you collect inpatient PT time in the inpatient MEPRS because they are doing inpatient institutional work?
      - Do you collect inpatient PT time in the outpatient MEPRS and then the inpatient expenses are wrong?

Coding Foundations

- Physical and Occupational Therapy Example:
  - When closing an inpatient service, such as orthopedics (inpatient ortho will now be done across town at another MTF),
    - How much additional PT is needed across town?
    - How much additional PT will be available at the MTF loosing the service?

Coding Foundations

Professional (what the privileged provider did)

- **Inpatient Hospital - a longstanding problem**
  - "Count" and "non-count" – supposed to be all inpatient was "non-count"
  - Optometry – occasionally, but not frequently by any means, an inpatient had a prior outpatient scheduled appointment → "is this related to inpatient hospitalization"
  - "Fudging" to get more counts led to incorrectly collecting inpatient consults as "not related"

Coding Foundations

Professional (what the privileged provider did)

- **Inpatient Hospital - problem**
  - Incorrect “count” inpatient consults in the outpatient “B” MEPRS
  - Original Managed Care Support Contracts based on MTFs doing same amount of “count” visits
  - What to do?
    - Enforce that inpatient consults are not count and have those MTFs that had “fudged” have to pay the extra for not meeting their MCSC goals? Even though they were doing the same amount of word as before?
    - Instruct everyone to code inpatient consults in the “B” MEPRS?

Coding Foundations

Professional (what the privileged provider did)

- **Inpatient Hospital - problem**
  - Changed query in CHCS Ambulatory Data Module (ADM) from “is this related to the inpatient admission” to “are you in the same service as the attending”
  - Inpatient consults (i.e., CPT 9925x) not a problem as there is no “non-facility practice expense” as it is obvious that these cannot be done in a doctor’s office
  - Problem with procedures done by “other than the attending service”

Coding Foundations

Inpatient Procedures by other than Attending Service Problem

- Automatically feed to “B” Outpatient Clinic MEPRS
- Credit in “B” for lumbar punctures and other consultant procedures
- Credit in “B” for second specialty in major surgeries
- Where is MEPRS time being collected? If time is collected in the “A” MEPRS, with RVUs in the “B” MEPRS
  - Inpatient Data is flowing to WAM/EAS IV
  - Receiving double payment in form of RWP and RVUs
- Procedures that could be done in a doctor’s office have associated “institutional” so double institutionals
- If billed, double billing institutionals, this is fraud

CMAC Detail Screen for Procedure Code: 62270
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
62270	**SPINAL FLUID TAP, DIAGNOSTIC**

Effective 01-Mar-06 **Correction** N/A **Term Date:** N/A

CMAC for Category 1	$74.22
Category of Provider	Facility Physician
CMAC for Category 2	**$189.80**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$63.08
Category of Provider	Facility Non-Physician
CMAC for Category 4	$161.33
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99251
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS State Code: DC
State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND

Procedure Code	Description
99251	INITIAL INPATIENT CONSULT

Effective	01-Mar-	**Correction**	N/A	**Term**	N/A

CMAC for Category 1	$39.33
Category of Provider	Facility Physician
CMAC for Category 2	**$39.33**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$33.43
Category of Provider	Facility Non-Physician
CMAC for Category 4	$33.43
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99241
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99241	**OFFICE CONSULTATION**

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	$37.60
Category of Provider	Facility Physician
CMAC for Category 2	**$57.49 (so facility cost is $20)**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$31.95
Category of Provider	Facility Non-Physician
CMAC for Category 4	$48.86
Category of Provider	Non-Facility Non-Physician

Coding Foundations

Not really institutional or professional

- Ambulance → HCPCS A-code
- Durable Medical Equipment → HCPCS

Both institutional and professional

- HCPCS C-codes, the pass-through codes

Goal 3, Providing globally accessible health and business information

1. Given a number of answers, 80% of the time, select the reasons why you need quality data to run a health care organization.

1.1. Example of using data to distribute resources

1.2. Review list of data uses with examples of how, if applied incorrectly, decisions may negatively impact beneficiaries

Need Data Quality

1. Legal Medical Record
2. Know Patient Population
   - Elevated blood pressure is not always hypertension
3. Prevention
   - New CPT category II and HCPCS G-codes for
     - Pay for Performance
     - Physician Voluntary Reporting
     - Physician Quality Reporting Initiative
   - Which children need vaccinations?
   - Which diabetics have had the foot check?

Need Data Quality

4. For manning
   - Where should the extra anesthesiologist go?
5. Determine which services should be closed
   - Should we close Cardiac Cath?
6. Non-covered benefits
   - Cosmetic surgery, if you don't code as cosmetic (an bill), you are using appropriated funds for an unauthorized service

Need Data Quality

7. How much work is actually being done by a provider?
   - External resource sharing
   - Circuit riders
   - Services in other MTF
   - Inpatient professional services
8. Need “clean” financial audit

Need Data Quality

9. Patient Categories (PATCATs) – used for reimbursement and empanelment
   - Change PATCAT when Active Duty retires
   - PATCAT needs to reflect when
     - Dependent is doing reserve duty
     - Dependent receives physical for Academy
   - Coast Guard – list sent to UBO at MTFs, but not fixed as responsible activity will not do
   - There is a canned report on M2 to see those patients where PATCAT does not match DEERS
     - Some shouldn't match, but "Coast Guard AD" as "Army AD" is a problem

Need Quality Data

10. Use the correct reports for your analysis
    - Coding Compliance Editor has a type of civilian RVU table, NOT the MHS RVUs
      - Incorrect for most surgical procedures, particularly LASIX and PRK
      - Incorrect for obstetrics
    - Coding Compliance Editor does NOT have all the outpatient professional services (e.g., it does NOT have telephone calls)

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS	LAB NAMES	30 CHARACTER DESC				
11200	00	A	0.62	1.45		REMOVAL OF SKIN TAGS				
11463	00	A	2.80	7.64		REMOVAL, SWEAT GLAND LESION				
10040	00	A	0.94	1.75		ACNE SURGERY OF SKIN ABSCESS				
0500F	00	A	0.83	1.58		Initial prenatal care visit				
0501F	00	A	0.83	1.58		Prenatal flow sheet				
0502F	00	A	0.83	1.58		Subsequent prenatal care				
				FULLY		FULLY			FULLY	FULLY
				Implement	NON-FAC	Implement	FACILITY		Implement	Implement
			WORK	NON-FAC	NA	FACILITY	NA	MP	NON-FAC	FACILITY	GLOB
HCPCS	Modifier	DESCRIPTION	RVU	PE RVU	Indicator	PE RVU	Indicator	RVU	TOTAL	TOTAL	DAYS
11200		Removal of s	0.77	1.04		0.76		0.04	1.85	1.57	010
11463		Removal, swe	3.94	6.84		2.69		0.54	11.32	7.17	090
10040		Acne surgery	1.18	1.01		0.79		0.05	2.24	2.02	010
0500F		Initial prenata	0.00	0.00		0.00		0.00	0.00	0.00	XXX
0501F		Prenatal flow	0.00	0.00		0.00		0.00	0.00	0.00	XXX
0502F		Subsequent p	0.00	0.00		0.00		0.00	0.00	0.00	XXX

Comparing MHS work RVUs (top report) and CMS work RVUs (bottom report)

- These are examples of how MHS is different that CMS because of "global period." Look at "Work RVUs."
- Global period is a billing issue. Codes were developed for billing, not collecting an individual's output. MHS collects and individual's output.

Legal Medical Record

Federal Rules of Evidence

Rule 803. Hearsay Exceptions; Availability of Declarant Immaterial

The following are not excluded by the hearsay rule, even though the declarant is available as a witness:

(6) **Records of regularly conducted activity.** A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, **a person with knowledge**, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record or data compilation, all as shown by the testimony of the custodian or other qualified witness, or by certification that complies with Rule 902(11), Rule 902(12), or a statute permitting certification, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term "business" as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

- *emphasis added to “a person with knowledge”

February 2007 “Helping Frontline Users Perform

“…a person with knowledge…”

- If a patient comes in for a suture check, which is done by the technician without the presence or direct supervision of the provider, and documented by the technician,
  - But not signed by the technician
  - And the only signature on the document is the provider’s signature
- Is this a legal medical record?

Legal Medical Record

No. It is not.

Counter signatures

- The individual doing the documentation signs that which he documented
- Another privileged provider reviews the documentation and annotates the reason, such as “reviewed and concur with,” and then signs

Initials are to be avoided unless there is a signature sheet in the record or the name and initials were used in another nearby entry so the documenter is always is obvious to a reader

Data Quality

- If a nurse is the only individual who interacts with the patient on the telephone, is it a legal medical record if the doctor signs it and takes credit for it?
- If a PT technician is the only one involved with patient care, is it a legal medical record if the Physical Therapist signs and takes credit for it?
- Don’t compromise your integrity or commit fraud for Relative Value Units.

Data Quality

How much do you trust the coded data at your MTF?

- Your MTF is required to audit coding every month.
- The TMA audit, following the MHS coding guidelines, had less than a 50% accuracy for outpatient, and less than 5% accuracy for Ambulatory Procedure Visits – do you know why?

NH CAMP PENDLETON	BAA	BAA - Internal Medicine Clinic	76091	MAMMOGRAM, BOTH BREASTS
NH PENSACOLA	BAA	BAA - Internal Medicine Clinic	76091	MAMMOGRAM, BOTH BREASTS
NH PENSACOLA	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
TRIPLER AMC-FT SHAFTER	BAA	BAA - Internal Medicine Clinic	76091	MAMMOGRAM, BOTH BREASTS
2ND MED GRP-BARKSDALE	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
NNMC BETHESDA	BCD	BCD - Breast Care Clinic	76091	MAMMOGRAM, BOTH BREASTS
L. WOOD ACH-FT. LEONARD WOOI	BBA	BBA - General Surgery Clinic	76091	MAMMOGRAM, BOTH BREASTS
NH CAMP LEJ EUNE	BBA	BBA - General Surgery Clinic	76091	MAMMOGRAM, BOTH BREASTS
319TH MED GRP-GRAND FORKS	BCB	BCB - Gynecology Clinic	76091	MAMMOGRAM, BOTH BREASTS
MONCRIEF ACH-FT. JACKSON	BCB	BCB - Gynecology Clinic	76091	MAMMOGRAM, BOTH BREASTS
WILLIAM BEAUMONT AMC-FT. BLIS	BBA	BBA - General Surgery Clinic	76091	MAMMOGRAM, BOTH BREASTS
MADIGAN AMC-FT. LEWIS	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
66TH MED GRP-HANSCOM	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
NACC KINGS BAY	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
12TH MED GRP-RANDOLPH	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
NBHC OCEANA	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
NBHC NTC SAN DIEGO	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
NBHC NAVSTA SEWELLS	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
HEIDELBERG MEDDAC	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
NH YOKOSUKA	BGA	BGA - Family Practice Clinic	76091	MAMMOGRAM, BOTH BREASTS
NH SIGONELLA	BAA	BAA - Internal Medicine Clinic	76091	MAMMOGRAM, BOTH BREASTS
48TH MED GRP-LAKENHEATH	BBA	BBA - General Surgery Clinic	76091	MAMMOGRAM, BOTH BREASTS
NBHC NAF ATSUGI	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS
NBHC NAF ATSUGI	BIA	BIA - Emergency Medical Clinic	76091	MAMMOGRAM, BOTH BREASTS
TRICARE OUTPATIENT-CHULA VIST	BHA	BHA - Primary Care Clinics	76091	MAMMOGRAM, BOTH BREASTS

1. Do you believe that Internal Medicine, Family Practice, General Surgery and Gynecology clinics are doing mammograms?

- wrong, but not a big problem, most of these were just once in an entire year

Data Quality

Are you collecting coded workload in the same MEPRS that you are collecting the facility costs and the labor costs?

- Radiology (perhaps technical component needs to be in radiology, and professional component in pain management)
- Anesthesia
- Physical Therapy
- Nutritional medicine for inpatients
- Inpatient professional services not in the attending's service

Data Quality

Professional staff do many non-codable, non-medical type tasks. Don’t code, and don’t distort to try to make them codable:

- Overseas clearances
- Hearing conservation
- ADAPT (Alcohol and Drug Abuse)
- Family advocacy
- Samples collected in the field for use in a training program…

Medical Necessity

- “Outpatient Admissions” don’t exist
  - Admit only if there is medical necessity
    - Not to “give nursing credit” when an Ambulatory Procedure Visit patient remains after the Ambulatory Procedure Unit closes for the evening
  - Patient remaining past midnight is not an automatic admission
  - Patient in observation more than 24 hours is not an automatic admission

Inappropriate Use of Funds

Cosmetic Procedures

- These are not covered benefits
- If you don’t charge the patient,
  - It is a misappropriation of funds and
  - The money is not available for authorized care
- Cosmetic procedures will have a primary diagnosis of V50.1

Institutional Considerations

Institutional is separate from professional for:

- Inpatient
- Emergency Department
- Observation
- Ambulatory Procedure Visits

Nursing and technician services are included in the institutional component and are not coded separately

Dietician services are included in the inpatient institutional component

Know When to Include Practice Expense RVUs

- Work RVUs may not reflect worth of the service
- Practice Expense RVUs are important to consider for clinics with significant institutional components
  - Cardiac catheterization, radiation oncology

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS	LAB NAMES	30 CHARACTER DESC				
93527	00	A	7.27	57.58		RT & LT HEART CATHETERS				
93528	00	A	8.99	60.02		RT & LT HEART CATHETERS				
93529	00	A	4.79	54.06		RT, LT HEART CATHETERIZATION				
93530	00	A	4.22	23.05		RT HEART CATH, CONGENITAL				
				FULLY		FULLY			FULLY	FULLY
				Implement	NON-FAC	Implement	FACILITY		Implement	Implement
			WORK	NON-FAC	NA	FACILITY	NA	MP	NON-FAC	FACILITY
HCPCS	Modifier	DESCRIPTION	RVU	PE RVU	Indicator	PE RVU	Indicator	RVU	TOTAL	TOTAL
93527		Rt & Lt heart c	7.27	50.46		50.46	NA	3.46	61.19	61.19
93527	TC	Rt & Lt heart c	0.00	47.14		47.14	NA	2.95	50.09	50.09
93527	26	Rt & Lt heart c	7.27	3.32		3.32		0.51	11.10	11.10
93528		Rt & Lt heart c	8.99	51.18		51.18	NA	3.57	63.74	63.74
93528	TC	Rt & Lt heart c	0.00	47.14		47.14	NA	2.95	50.09	50.09
93528	26	Rt & Lt heart c	8.99	4.04		4.04		0.62	13.65	13.65
93529		Rt, lt heart catl	4.79	49.42		49.42	NA	3.28	57.49	57.49
93529	TC	Rt, lt heart catl	0.00	47.14		47.14	NA	2.95	50.09	50.09
93529	26	Rt, lt heart catl	4.79	2.28		2.28		0.33	7.40	7.40
93530		Rt heart cath,	4.22	18.89		18.89	NA	1.34	24.45	24.45
93530	TC	Rt heart cath,	0.00	16.95		16.95	NA	1.05	18.00	18.00
93530	26	Rt heart cath,	4.22	1.94		1.94		0.29	6.45	6.45

Look at the Practice Expense – this is your workload too

Various Data Bases

Understand what each data base represents

- Workload Assignment Module (WAM)/ Expense Assignment System (EAS) IV – only “count” encounters
- Your server – has modifiers and quantities
- MHS Mart (M2) – does not have modifiers and quantities, does have count and non-count
- Coding Compliance Editor – only use this to check out coder productivity – do NOT use for provider productivity

Using Data Correctly

- The Relative Value Units (RVUs) in the Coding Compliance Editor (CCE) are NOT the MHS RVUs.
  - CCE does not use MHS RVUs
    - OB, ophthalmology, surgical specialties, and many other clinics not correctly represented
  - Telephone calls do not flow to CCE so 10% of Army encounters and 8% of Navy and AF encounters are not in CCE

Prevention

- Pay for Performance (P4P) → Physician Voluntary Reporting Program (PVRP) → Physician Quality Reporting Initiative (PQRI)
  - Method to track preventive activities done
  - Usually for chronic, but some acute
  - Usually use HCPCS G-codes for inpatient prevention
  - Usually use CPT category II codes for outpatient prevention
  - Part of the encounter, so usually don't have separate RUVs
    - In MHS use the prenatal codes to indicate individual encounters due to obstetrics being a global code
  - In civilian sector, if your practice collects these data, you will receive a higher reimbursement from CMS
  - MHS is very interested in these as prevention is
    - Good for our patients
    - Best way to provider health care

February 2007 "Helping Frontline Users Perform

Prevention – CPT© category II codes

- Adult Diabetes (12 measures)
- Asthma (2)
- Chronic Obstructive Pulmonary Disease (12)
- Chronic Stable Coronary Artery Disease (10)
- Community-acquired Bacterial Pneumonia (12)
- Emergency Medicine (9)
- End Stage Renal Disease (5)
- Eye Care (8)
- Gastroesophageal Reflux Disease (5)
- Geriatrics (7)
- Heat Failure (11)
- Hypertension (2)
- Major Depressive Disorder (5)
- Melanoma (3)
- Osteoarthritis (7)
- Osteoporosis (6)
- Pediatric Acute Gastroenteritis (4)
- Perioperative Care (6)
- Prenatal Testing (10)
- Preventive Care and Screening (6)
- Stroke and Stroke Rehabilitation (9)

Prevention – HCPCS G-Codes G8006-G9139

- Acute myocardial infarction (6)
- Pneumonia (3)
- Diabetes hemoglobin A1c (4)
- Diabetes low-density lipoprotein (3)
- Diabetes blood pressure (4)
- Heart failure and prior MI (9)
- Coronary artery disease (3)
- Assessed for osteoporosis (3)
- Assessed for falls (3)
- Assessed for hearing (3)
- Assessed for urinary incontinence (3)
- ESRD – urea reduction ratio (3)
- ESRD – hematocrit (3)
- ESRD – vascular access (3)
- New COPD – smoking cessation (2)
- Osteoporosis –
  - Ca++ and vitamin D (2)
  - Antiresorptive therapy (2)
- Nontraumatic fx – DEXA (2)
- Flu shot during season (3)
- Mammogram (3)
- Pneumococcal vaccine (3)
- Antidepressant for
  - 12 week acute phase (3)
  - 6 month continuous tx (3)
- Antibiotic prior to incision (3)…

Prevention

All code sets are not the same

- AMA CPT 2007 code book went to print prior to release of July, October and December releases, so will not show all that are available
- Ingenix CPT 2007 code book went to print prior to release of October and December releases, so will not show all that are available
- MHS CPT 2007 code sets went to testing prior to December release, so those codes released in December will not be available with this release

Goal 4, Transformation to performance based management

2. Given a number of examples of poor data and quality data, 80% of the time, select quality data examples.

2.1. Telephone calls

2.2. Inpatient professional services

2.3. Anesthesia

Data Quality - Telephone Calls

1. Provider/patient interaction (not just nurse and patient)
2. Opportunity to start, stop or change care
3. Documented

4. Not a continuation of a previous encounter
   Calling patient about strep test results
5. Not telephone nurse triage
6. Not the same as civilian use of 99371/99372, 99373

Data Quality - Inpatient Professional Services

1. Do NOT code inpatient services in AHLTA. AHLTA is an outpatient documentation system
2. Do NOT code institutional services, particularly those done by technicians, nurses, and dieticians
3. Initial documentation must include history, exam, and decision making
4. When doing inpatient services, when there are inpatient specific codes, use them (e.g., initial hospitalization, subsequent hospital care, discharge care, inpatient consultation)

Quiz 1

Select the reasons why you need quality data to run a health care organization.

- To make informed decisions
- To have a legal medical record
- To know who is doing the service
- To know your population's health issues

Quiz 1

Answer – all are reasons for quality data when running a health care organization

Quiz 2

Example of poor data and quality data

- Documentation only signed by someone without first hand knowledge of the episode of care
- Using Coding Compliance Editor (CCE) reports to determine **provider** productivity
- Using Coding Compliance Editor (CCE) reports to determine **coder** productivity
- Using CHCS reports from your server (which includes all 3 E&M, modifiers, quantity) to determine productivity

Quiz 2

Example of poor data and quality data

- Poor - Documentation only signed by someone without first hand knowledge of the episode of care
- Poor - Using Coding Compliance Editor (CCE) reports to determine **provider** productivity
- Quality - Using Coding Compliance Editor (CCE) reports to determine **coder** productivity
- Quality - Using CHCS reports from your server (which includes all 3 E&M, modifiers, quantity) to determine productivity

Goals

1. **Given a number of answers, 80% of the time select the reasons why you need quality data to run a health care organization.**
   - **Goal 3, Providing globally accessible health and business information to enhance mission effectiveness.**
2. **Given a number of examples of poor data and quality data, 80% of the time select quality data examples.**
   - **Goal 4, Transformation to performance based management for both force health protection and delivery of the health care benefit.**

Questions?

CMAC Detail Screen for Procedure Code: 99241
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC
State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99241	OFFICE CONSULTATION

Effective Date:	01-Mar-06	**Correction Date:**	N/A	**Term Date:**	N/A

CMAC for Category 1	$37.60
Category of Provider	Facility Physician
CMAC for Category 2	**$57.49**
Category of Provider	Non-Facility Physician
CMAC for Category 3	$31.95
Category of Provider	Facility Non-Physician
CMAC for Category 4	$48.86
Category of Provider	Non-Facility Non-Physician

CMAC Detail Screen for Procedure Code: 99217
Locality Code: 317
Locality Name: DC + MD/VA SUBURBS
State Code: DC State Name: DISTRICT OF COLUMBIA
State Code: MD State Name: MARYLAND
State Code: VA State Name: VIRGINIA

Procedure Code	*Description*
99217	**OBSERVATION CARE DISCHARGE**

Effective Date: 01-Mar-06 **Correction Date:** N/A **Term Date:** N/A

CMAC for Category 1	$78.05
Category of Provider	Facility Physician
CMAC for Category 2	$78.05
Category of Provider	Non-Facility Physician
CMAC for Category 3	$66.34
Category of Provider	Facility Non-Physician
CMAC for Category 4	$66.34
Category of Provider	Non-Facility Non-Physician

HCPCS	MOD	OWNER	Work RVUS	EAS IV RVUS	LAB PRINT	30 CHARACTER DESC	
99241	00	A	0.64	1.28		OFFICE CONSULTATION	
99242	00	A	1.29	2.33		OFFICE CONSULTATION	
99243	00	A	1.72	3.11		OFFICE CONSULTATION	
99244	00	A	2.58	4.40		OFFICE CONSULTATION	
99245	00	A	3.42	5.69		OFFICE CONSULTATION	
99281	00	A	0.33	0.42		EMERGENCY DEPT VISIT	
99282	00	A	0.55	0.69		EMERGENCY DEPT VISIT	
99283	00	A	1.24	1.55		EMERGENCY DEPT VISIT	
99284	00	A	1.95	2.42		EMERGENCY DEPT VISIT	
99285	00	A	3.06	3.78		EMERGENCY DEPT VISIT	

			FULLY		FULLY			FULLY	FULLY
			Implement	NON-FAC	Implement	FACILITY		Implement	Implement
		WORK	NON-FAC	NA	FACILITY	NA	MP	NON-FAC	FACILITY
HCPCS	DESCRIPTION	RVU	PE RVU	Indicator	PE RVU	Indicator	RVU	TOTAL	TOTAL
99241	Office cons	0.64	0.64		0.22		0.05	1.33	0.91
99242	Office cons	1.29	1.04		0.46		0.10	2.43	1.85
99243	Office cons	1.72	1.39		0.63		0.13	3.24	2.48
99244	Office cons	2.58	1.83		0.92		0.16	4.57	3.66
99245	Office cons	3.42	2.28		1.24		0.21	5.91	4.87
99281	Emergency	0.33	0.09	NA	0.09		0.02	0.44	0.44
99282	Emergency	0.55	0.14	NA	0.14		0.04	0.73	0.73
99283	Emergency	1.24	0.31	NA	0.31		0.09	1.64	1.64
99284	Emergency	1.95	0.47	NA	0.47		0.14	2.56	2.56
99285	Emergency	3.06	0.72	NA	0.72		0.23	4.01	4.01